

SURGERY

UNDER THE CHARGE OF

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A Study of the Anatomy, Pathology, and Treatment of Uterine Prolapse, Rectocele and Cystocele.—FRANK (*Surg., Gynec. and Obst.*, 1917, xxiv, 42) says that with very few exceptions, anterior and posterior colporrhaphy combined with either the Alexander operation or ventrofixation are applicable to all cases of prolapse or cysto-rectocele and retroversion both during and after the childbearing period. The technic of these plastic operations can be learned as precisely as that of inguinal hernia, if the student is taught the regional anatomy. To obtain the proper dimensions of the reconstructed canal, however, requires considerable experience and proficiency in operating. The disadvantage of the technic, which is described at length, is the considerable time required. A rapid operator cannot complete curettage, amputation of the cervix, anterior and posterior colporrhaphy, ligation of the tubes, and ventrofixation in much less than ninety minutes. In some cases (though very rarely) it may prove advisable to perform the vaginal plastic and the abdominal fixation at separated sessions (two weeks' interval).

The Actual Cautery in the Treatment of Chronic Ulcer of the Stomach.—SCUDDER and HARVEY (*Surg., Gynec. and Obst.*, 1916, xxiii, 718) investigated experimentally, on dogs, Balfour's method of treating certain chronic ulcers of the lesser curvature of the stomach by the application of the actual cautery followed by suture of the cauterized area. It appears that the suture of the cauterized margins of the stomach wall is attended by practically a normal reparative process similar to the reparative process following a simple incision with the knife. The method is applicable to a chronic ulcer seated upon the lesser curvature so far away from the pylorus as to make its removal by excision difficult. Such an ulcer may be cauterized from the center out, as suggested by Balfour, so that the loss of substance occasioned by the cauterization may be as large as $1\frac{1}{2}$ inches or more in diameter and the edges may be then approximated with the assurance of a proper healing of the wound. Ulcers seated on the posterior wall of the stomach which are safely approached by a gastrotomy incision may have their edges thoroughly cauterized and also the base thoroughly cauterized even when it is adherent to the pancreas, and be sutured with the assurance to the surgeon that the reparative process will proceed satisfactorily. Certain chronic ulcers adherent to the posterior parietics and pancreas do not lend themselves to easy and safe excision and suture. The cautery is sometimes applicable to this special group of cases. It will destroy any beginning cancer in the edges of the ulcer if the cauterization is thoroughly done. In order to close the stomach following a simple excision of a portion of

the stomach wall, a very large wound remains to be sutured. Following the use of the cautery no such large gaping wound exists, and the stomach is closed more readily than after a wide excision by the knife. With cauterization as with simple excision, the stomach should be carefully mobilized and the part to be operated on controlled, so that the portion actually cauterized is rendered accessible. The suture material employed in human cases in each instance has been No. 1 chromic catgut. It has not been found necessary to reinforce the sutured area by interrupted linen suture of the peritoneal surface in all cases. If it is possible to place these interrupted linen sutures it is wise to do so. Following any extensive plastic of the stomach, a gastro-enterostomy should be done (Mayo).

Hemostasis by Interposition of Muscle, Fat and Fascia in Parenchymatous Organs.—RISLEY (*Surg., Gynec. and Obst.*, 1917, xxiv, 85) carried out a series of 12 experiments on dogs to determine the value of the above tissues in stopping hemorrhage in such organs as the kidney and liver, when other forms of hemostasis are either impossible or undesirable. He found that the ideal hemostatic in wounds of parenchymatous organs is interposed muscle taken at the time of operation from the patient's own body. Such muscle in order to most effectively stimulate fibrin formation should be jaggedly cut with a knife and not crushed as with a scissors cut, nor should its hemostatic properties be extracted by its contact with salt solution. Fascia and fat act to a more limited degree as hemostatics: fascia more than fat, but both very much less than muscle. In the liver, however, both fascia and fat seem at times to be very efficient hemostatics. These tissues readily unite to the bleeding surface to which they are sewed, and form a smooth, solid scar. Microscopical examination of specimens removed at varying intervals after operation show, in the absence of sepsis, a beginning transformation of muscle into fibrous tissue, a partial absorption of fat and change into fibrous tissue, no changes in fascial transplants, in practically every case a firm blending of the interposed tissue with the cut surface of the parenchymatous tissue, the formation of new blood channels and no degenerative changes of any note. He concludes therefore, that muscle, fascia and fat can be safely interposed into these tissues and after acting as immediate hemostatics later undergo fibrous change and form a firm union with the parenchymatous tissue.

THERAPEUTICS

UNDER THE CHARGE OF

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Some Studies of Theocin.—CHRISTIAN (*Arch. Int. Med.*, 1916, xviii, 606) says that a fairly complete study of a small group of patients with acute nephritis or chronic nephritis or cardiorenal disease indicates